STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/24/11 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Renaissance Village was found in not compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and all resident rooms on the 300 hall. The facility has a capacity of 96 and had a census of 90 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/31/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 single fire doors entering the kitchen, a hazardous area, was arranged to automatically close and latch. This deficient practice could affect any of the residents in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 08/24/11 at 1:40 p.m., the fire door adjacent to the three compartment sink failed to latch into the frame. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K0029	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The closer and the top hinge on the kitchen door were adjusted allowing for proper latching. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* All facility doors were inspected for proper latching. *MEASURES FOR PREVENTION* All facility doors are checked monthly for proper operation. *QA FOR PREVENTION* A monthly log is kept by maintenance employee or designee and any future issues will be presented by the Environmental Manager at the monthly QA&A meeting for discussion and recommended plans of action. *EFFECTIVE DATE* The effective date is September 6, 2011.	09/06/2011

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K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 6 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects 32 of 90 residents and visitors. Findings include: Based on observation on with the Maintenance Supervisor on	K0038	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The exit code (mmyy) to disengage the magnetic lock on all 6 exit doors is posted at each door. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* The exit code (mmyy) to disengage the magnetic lock on all 6 exit doors is posted at each door. *MEASURES FOR PREVENTION* All 6 exit doors are checked monthly for continued posting of the code. *QA FOR PREVENTION* A monthly preventative maintenance log is kept by maintenance employee or designee and any future issues will be presented by the Environmental Manager at the monthly QA&A meeting for discussion and recommended plans of action if required. *EFFECTIVE DATE* The effective date is September 6, 2011.	09/06/2011

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	08/24/11 from 11:30 a.m. to 3:00 p.m., all exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. Based on interview with the Director of Nursing at 2:30 p.m., not all residents have a clinical diagnosis to be in a secure building. She stated residents without the clinical diagnosis requiring specialized security measures did not have access to the code. 3.1-19(b)			
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with the requirements of NFPA 13,	K0056	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The identified unsupported armover of the sprinkler pipe was modified by an outside vendor to comply with proper code.	09/09/2011

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	Standard for the Installation of Sprinkler Systems, 1999 edition. NFPA 13, Section 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect any resident on the 200 hall and at the nurses' station. Findings include: Based on observation with the Maintenance Supervisor on 08/24/11 at 2:10 p.m., there was an unsupported armover of the sprinkler pipe measuring twenty seven inches in length above the ceiling tile near the 200 hall fire doors. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		*IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* The building was inspected for proper sprinkler head armover support. No other issues noted. *MEASURES FOR PREVENTION* The building is monitored annually for proper armover support. *QA FOR PREVENTION* This building is monitored annually for proper armover support. An annual log is kept by maintenance employee or designee and any future issues will be presented by the Environmental Manager at the next scheduled quarterly QA&A meeting for discussion and recommended plan of action if required. *EFFECTIVE DATE* The effective date is September 9, 2011.	

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K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to document and conduct weekly tests for 1 of 1 fire pumps. NFPA 25, Table 5-1.1 and then 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions such as heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, and suction reservoir is full. Additionally, a no flow ten minute pump test shall be performed weekly. This deficient practice affects all occupants. Finding include: Based on record review with the Maintenance Supervisor on 08/24/11 at 10:40 a.m., the facility was unable to provide documentation of a weekly inspection of the fire pump. Based on interview with the	K0062	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* A weekly, no flow, ten minute pump test is conducted by maintenance personnel. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* A weekly, no flow, ten minute pump test is conducted by maintenance personnel. *MEASURES FOR PREVENTION* A weekly operational fire pump test log for the pump test is maintained by maintenance personnel. *QA FOR PREVENTION* A weekly log of the fire pump test is kept by maintenance employee or designee and any future issues will be presented by the Environmental Manager to the administrator immediately and at the monthly QA&A meeting for discussion and recommended plan of action if required. *EFFECTIVE DATE* The effective date is September 9, 2011.	09/09/2011

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	Maintenance Supervisor at the time of record review, he was not aware of this requirement. 3.1-19(b)			
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation and interview; the facility failed to ensure an undetermined number of dampers in the ceiling vents were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated	K0067	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* Maintenance is performed every 4 years on all fire dampers, including fusible link removal, verification of damper functionality and closure, latch inspection, and lubrication of moving parts. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* Maintenance is performed every 4 years on all fire dampers, including fusible link removal, verification of damper functionality and closure, latch inspection, and lubrication of moving parts. *MEASURES FOR PREVENTION* A log documenting fire damper maintenance every 4 years will be maintained by maintenance personnel. *QA FOR PREVENTION* A log documenting fire damper maintenance every 4 years is kept by maintenance personnel and any future issues will be	09/09/2011

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	as necessary. This deficient practice affects all occupants. Findings include: Based on interview with the Maintenance Supervisor on 08/24/11 at 11:20 a.m. when asked if there were fire dampers in the ventilation system, he stated there were but he was unable to provide an exact number. When asked for documentation of an inspection, he stated there was no documentation available. Based on observation with the Maintenance Supervisor on 08/24/11 at 2:01 p.m., there was a damper at the 300 hall fire wall. 3.1-19(b)		presented by the Environmental Manager or designee to the administrator immediately and at the next scheduled monthly QA&A meeting for discussion and recommended plan of action if required. *EFFECTIVE DATE* The effective date is September 22, 2011.	
K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review; the facility failed to enforce the policy for the use of 1 of 1 portable space	K0070	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The heating element of the identified activity room fireplace was disconnected to eliminate any	09/09/2011

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	heaters. This deficient practice could affect any resident in the activity room. Findings include: Based on an observation with the Maintenance Supervisor on 08/24/11 at 12:55 p.m., there was an electric fire place in the residents' activity room. Based on an interview with the Maintenance Supervisor at the time of observation, the electric fire place does blow heated air into the room. Based on record review with the Maintenance Supervisor on 08/24/11 at 11:30 a.m., the facility does not allow space heaters in the facility. 3.1-19(b)		possibility of heat emanating from the fireplace. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* The heating element of the identified activity room fireplace was disconnected to eliminate any possibility of heat emanating from the fireplace. *MEASURES FOR PREVENTION* The identified fireplace is inspected annually for safety issues. Any portable, decorative fireplaces purchased in the future, will also have the heating element disconnected for resident safety. *QA FOR PREVENTION* An annual preventative log is kept by maintenance personnel and any future issues will be presented by the Environmental Manager or designee to the administrator immediately and at the next scheduled monthly QA&A meeting for discussion and recommended plan of action if required. *EFFECTIVE DATE* The effective date is September 9, 2011.	
K0147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord were not used as a substitute for fixed	K0147	*CORRECTIVE ACTION FOR AFFECTED RESIDENTS* The identified extension cord in the MDS office was removed and replaced with a compliant power strip. The identified extension cord in the 300 hall furnace room	09/09/2011

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	wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on observations with the Maintenance Supervisor on 08/24/11 between 12:20 p.m. and 12:30 p.m., a heavy weight extension cord was plugged in and providing power to a power strip in the MDS office and a heavy weight extension cord was providing power for a modem in the 300 hall furnace room. These were acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)		was replaced with a receptacle for the modem. *IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS* The identified extension cord in the MDS office was removed and replace with a compliant power strip. The identified extension cord in the 300 hall furnace room was replaced with a receptacle for the modem. *MEASURES FOR PREVENTION* The building continues to be monitored quarterly for improper use of extension cords. *QA FOR PREVENTION* A log is kept quarterly by maintenance personnel and any future issues will be presented by the Environmental Manager or designee at the monthly QA&A meeting for discussion and recommended plan of action if required. *EFFECTIVE DATE* The effective date is September 9, 2011.	